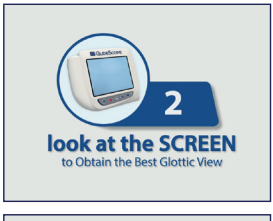
GLIDESCOPE® TITANIUM 4-STEP TECHNIQUE

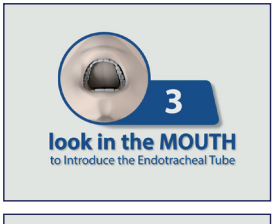
WARNING

When you are guiding the endotracheal tube to the distal tip of the video laryngoscope, ensure that you are looking in the patient's mouth, not at the video monitor screen. Failure to do so may result in injury to the tonsils or soft palate.

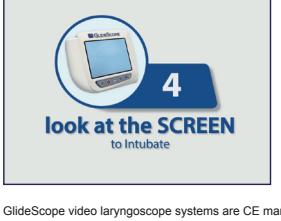
Looking directly into the patient's mouth and with the GlideScope in the left hand, introduce the video laryngoscope into the midline of the oral pharynx.



With the laryngoscope inserted, look to the monitor to identify the epiglottis, then manipulate the scope to obtain the best glottic view.



Looking directly into the patient's mouth, not at the screen, carefully guide the distal tip of the tube into position near the tip of the laryngoscope.



Look to the monitor to complete the intubation; gently rotate or angle the tube to redirect as needed.

GlideScope video laryngoscope systems are CE marked in accordance with the Medical Device Directive, and the Verathon Inc. quality system is Quality System Certified to ISO 13485:2003 standards.

GLIDESCOPE® TITANIUM

TIPS FOR VIDEO LARYNGOSCOPE INSERTION

- Insert the GlideScope video laryngoscope down the midline of the tongue to the epiglottis. The technique is the same for LoPro and MAC blades, whether reusable or single use.

- The GlideScope video laryngoscope may be used to produce a Macintosh indirect lift of the epiglottis or a Miller lift.

- Intubations using GlideScope video laryngoscopes require approximately 0.5–1.5 kg of lifting force.

- Use of an endotracheal tube stylet is recommended. The GlideRite® Rigid Stylet is designed to complement the angle of the GlideScope LoPro video laryngoscope to facilitate intubation. A malleable stylet may be used with a 60–90° angle.

- To aid the passage of the endotracheal tube (ETT), withdraw the stylet (approximately 5 cm) while gently advancing the ETT. A 1-cm withdrawal of the laryngoscope also may be beneficial to reduce the viewing angle and allow the glottis to drop.

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